STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155729	A. BUILDING 00 B. WING	08/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS HERITAGE	12011 WHITTERN RD MONROEVILLE, IN 46773

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: August 1, 2, 5, 6, and 7, 2013. Facility number: 002549 Provider number: 155729 AIM number: 200289420 Survey Team: Julie Call, RN TC (August 1, 5, 6, and 7, 2013) Virginia Terveer, RN (August 1, 5, 6, and 7, 2013) Sue Brooker, RD Angela Strass, RN Census bed type: SNF/NF: 55 Total: 55 Census payor type: Medicare: 2 Medicaid: 41 Other: 12 Total: 55 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on August	F000000	Preparation and execution of this plan of correction does not constitute admission or agreement by provider to the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. adams-Heritage maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, adams-Heritage asserts that it is in	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	9, 2013 by Randy Fry RN.		substantial compliance with regulations governing the operation of long term care facilities, and this Plan of Correction in its entirety constitutes this provider's allegation of compliance and, thereby, we request resurvey to verify such as of August 15, 2013. **Further, we request desk review (paper compliance)** **for compliance, if acceptable.** Completion dates are provided for procedural processing purposes to comply with federal and state regulations, and correlate with the most recent contemplated accomplished corrective action. These do not necessarily chronologically correspond to the date that Adams Heritage is under the opinion that it	

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			was in compliance with the requirements of participation or that corrective action was necessary.	

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to initiate a care plan for paranoia for 1 resident (Resident #56) of 36 residents reviewed for care plans. Findings include: Review of the clinical record for Resident #56 on 8/5/13 at 10:13 a.m., indicated the following: diagnoses included, but were not limited to, CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease), HTN (hypertension),	F000279	It is the policy of this provider to develop, review and revise residents' comprehensive care plan based on needs identified in comprehensive assessment. ***1. What corrective action will be accomplished for*** ***those residents found to have been affected by this***	08/09/2013

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	diabetes mellitus, dementia, depression, and anxiety. A Nurse's Notes for Resident #56, dated 9/29/12, indicated she was anxious and refusing to wear O2 (oxygen) as ordered, stating "You are poisoning me with this." A Social Service Progress Note for Resident #56, dated 10/1/12, indicated nursing documented on 9/29/13, she was refusing to wear her O2 and stated she was being poisoned. A Behavior Health Assessment/Evaluation for Resident #56, dated 10/3/12 and written by a Psychologist, indicated she was referred for an evaluation and assessment of her thought process and moods due to periods of anxiety and paranoia. The evaluation also indicated she had begun to refuse care. The impression from the evaluation indicated her presentation was of a combination of psychomotor restlessness and paranoia about her care and surroundings plus cognitive loss. The impression from the evaluation also indicated a low dose of a routine antipsychotic like Seroquel 12.5 mg (milligrams) might be considered to address the		***alleged deficient practice?*** A care plan for Paranoia was completed for Resident #56 on August 8, 2013. ***2. How other residents having the potential to be*** ***affected by the same deficient practice will be*** ***identified and what corrective action(s) will be taken?*** Other residents that could be affected by the same deficient practice would be identified as those with a diagnosis of Paranoia. None were so identified. ***3. What measures will be put into place or what*** ***systemic changes will be made to ensure that the*** ***deficient practice does not occur?***	

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	paranoia and the belief staff were poisoning her. A Social Service Progress Note for Resident #56, dated 10/10/12, indicated she was anxious and voiced people were laughing at her. A Social Service Progress Note for Resident #56, dated 10/11/12, indicated she continued to display paranoia and continued to remove her oxygen. The note also indicated she was observed swearing at family and becoming easily agitated. A physician's order for Resident #56, dated 10/11/12, indicated Seoquel 50 mg every day HS (hour of sleep). A Behavior Summary for Resident #56, dated 10/17/12, indicated she had displayed episodes of delusional thinking and paranoia. The summary also indicated she was receiving Seroquel 50 mg HS. Facility care plans for Resident #56 included the problem areas of: depression, potential side effects of taking anti-depressant medication, anxiety, potential side effects of taking anti-anxiety medication, and potential side effects of taking anti-psychotic medication. There was		Social Service will conduct audits on residents who have had a behavioral evaluation and assure that if care plan changes were necessary, they were made at that time. ***4. How the corrective action(s) will be monitored to*** ***ensure the deficient practice will not recur?*** Information gathered from the audits will be forwarded to the QA committee for recommendations and review monthly for two months, then quarterly thereafter. QA committee will recommend time frame for continued monitoring. ***5. By what date the systemic changes will be***	

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	no facility care plan for the problem area of paranoia, and no non-pharmacological interventions implemented to address paranoia. Social Service staff #2 was interviewed on 8/6/13 at 11:34 a.m. During the interview she indicated she could not locate any care plan for Resident #56 concerning the problem of her paranoia. She also indicated the development of care plans pertaining to behaviors and psychiatric diagnoses were to be jointly developed between Nursing and Social Service. A policy on developing care plans was requested on 8/6/13 at 4:00 p.m. from the Administrator and the Director of Nursing. A policy concerning the development of care plans was not provided. 3.1-35(a)		***completed?*** August 9, 2013.	

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure physician orders were followed for completion of a laboratory test for 1 of 10 residents who met the criteria for the unnecessary medication review. (Resident #5) Findings include: A review of Resident #5's clinical record began on 8-5-2013 at 10:23 a.m., indicated diagnoses included but were not limited to, cerebral vascular attack, speech disturbance, anemia, atrial fibrillation, hypertension, depression, thrombocytopenia, anxiety, dypnea, tremors and dehydration. The April 2013 recapitulation of physician orders was signed by the physician on 4-1-2013. The April 2013 recapitulation indicated laboratory orders for a basic metabolic panel (BMP) and a complete blood count (CBC) to be completed every 3 months.	F000282	It is the policy of this provider to ensure that residents with lab orders are scheduled per order indicated. ***1. What corrective action(s) will be accomplished for*** ***those residents found to have been affected by the*** ***alleged deficient practice?*** Resident #5 labs (BMP & CBC) are scheduled for every 3 months per order as of August 6, 2013. ***2. How will other residents having the potential*** ***to be affected by the same deficient practice***	08/13/2013

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	A consultant pharmacist recommendation dated 2-14-2013, indicated Resident #5 had labs ordered every 3 months for a BMP and CBC. The consultant pharmacist indicated last laboratory draws were done in August 2012 and since the resident was off hospice to be sure the labs were completed. A review of laboratory results in Resident #5's clinical record indicated a CBC and BMP were completed on 2-26-2013 and a BMP was completed on 5-14-2013. There were no laboratory results for a CBC as ordered for May 2013. During an interview with the Director of Nursing (DON) on 8-6-2013 at 9:31 a.m., the DON indicated the lab orders for the CBC from the physician recapitulation for April 2013 were not entered in the laboratory book and the CBC was not done. During an interview with Licensed Practical Nurse (LPN) #5 on 8-6-2013 at 2:41 p.m., LPN #5 indicated the Medical Records staff would write the routine lab orders from the Physician recapitualtions on a calendar in the laboratory book and LPN #5 indicated she prepared the laboratory request		***be identified and what corrective action(s) will*** ***be taken?*** Other residents having the potential to be affected by the same deficient practice would be identified as those with lab recommendations from the consultant pharmacist. From April 2013 to present, all pharmacy recommendations were audited to assure that all pharmacy recommendations have been addressed. ***3. What measures will be put into place or what*** ***systemic changes will be made to ensure that the*** ***deficient practice does not recur?*** A system has been developed to assure the recommendations are reviewed	

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	slips from the calendar. During an interview with the Medical Records Staff #6 on 8-7-2013 at 8:40 a.m., the Medical Records Staff #6 indicated she did not receive a copy of the Consultant Pharmacist's Medication Regimen Review dated 2-14-2013 which recommended labs for a CBC and BMP every 3 months for Resident #5. She indicated she did not know to place the CBC and BMP on the lab calendar. Further interview with the Medical Records Staff #6 on 8-7-2013 at 8:42 a.m, indicated she was not responsible for reviewing the recapitulations for lab orders to be placed on the lab calendar. She indicated the facility did not have a system in place to double check the recapitulations to be sure lab orders were placed on the laboratory calendar. 3.1-35(g)(2)		monthly. Pharmacist's report will be sent to DON/Designee. DON/Designee will distribute the recommendations to the appropriate physician. DON/Designee will monitor/audit monthly for return response and accuracy of order. ***4. How the corrective action(s) will be monitored*** ***to ensure the deficient practice will not recur?*** Result of the audit will be submitted to the QA Committee for review and recommendation monthly for two months and quarterly thereafter. QA Committee will recommend time frame for continued monitoring.	

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			5. What date will the systemic changes be completed? August 13, 2013.	

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F000315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview and record review the facility failed to ensure catheter tubing was kept off the floor for 1 resident (Resident #50) of 2 residents who met the criteria for urinary catheter. Findings include: Review of the clinical record for Resident #50 on 8/7/13 at 8:39 a.m., indicated the following: diagnoses included, but were not limited to, BPH (benign prostatic hypertrophy), urinary retention, and bladder cancer. Physician's orders for Resident #50, dated for the month of July, 2013, indicated a Foley (indwelling urinary) catheter. 1. During an observation of the lunch meal in the dining room on 8/1/13 at	F000315	It is the policy of this provider to ensure that residents' catheter tubing be kept off floor. ***1. What corrective action(s) will be*** ***accomplished for those residents found to have*** ***been affected by the alleged deficient practice?*** Resident care guide for Resident #50 has been updated to include tubing to be kept off the floor. ***2. How other residents having***	08/15/2013

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	11:26 a.m., Resident #50 was observed seated in his wheelchair at a dining room table. His catheter bag was suspended underneath his wheelchair but the catheter tubing was observed resting on the floor. 2. During an observation of the breakfast meal in the dining room on 8/2/13 at 8:30 a.m., Resident #50 was observed seated in his wheelchair at a dining room table. His catheter bag was suspended underneath his wheelchair but the catheter tubing was observed resting on the floor. At 9:10 a.m., Resident #50 was observed being pushed in his wheelchair from the dining room to his room by CNA (Certified Nursing Assistant) #5. His catheter tubing was observed dragging on the floor. 3. During an observation on 8/6/13 at 11:55 a.m., Resident #50 was observed seated in his wheelchair next to the nursing station. His catheter bag was suspended underneath his wheelchair but the catheter tubing was observed resting on the floor. CNA #3 and CNA #4 were interviewed on 8/7/13 at 8:50 a.m. During the interview they indicated		***the potential*** ***to be affected by the same deficient practice*** ***will be identified and what corrective action (s)*** ***will be taken?*** Other residents having the potential to be affected by the same deficient practice will be identified as those having indwelling urinary catheters. 4 were so identified. The Resident Care Guide for those residents were updated to include that tubing to be kept off the floor. This was completed on August 15, 2013. ***3. What measures will be put into*** ***place or what systemic changes will be made*** ***to ensure that the deficient practice does not***	

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	catheter tubing needed to be suspended underneath the wheelchair. They also indicated the tubing should not touch the floor. A facility care plan for Resident #50, with a start date of 7/6/12, indicated the problem area of potential for complications related to use of catheter. Approaches to the problem included, but were not limited to, secure catheter tubing to leg to avoid pulling or trauma and ensure drainage bag is off the floor and below bladder level. The care plan did not indicate to keep the catheter tubing from resting on the floor. A current facility policy "Catheter (indwelling) care and removal", dated 2006 from Lippincott Williams & Wilkins and provided by the DON on 8/7/13 a 10:39 a.m., indicated "...Intended to prevent infection... Avoid raising the drainage bag above bladder level...." The policy did not indicate to keep the catheter tubing from resting on the floor. 3.1-41(a)(2)		***recur?*** An audit tool was developed and DON/designee will audit catheter tube placement on first shift for one week, then daily on rotating shifts for one week, then DON/designee will continue to monitor it randomly. An in-service will be held on August 22, 2013 which will include the education recap and results of the audits to the staff. ***4. How the corrective action (s) will be monitored to*** ***ensure the deficient practice will not recur?*** Information gathered from the audits will be forwarded to the QA committee for recommendations and review	

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			monthly, for two months, then quarterly thereafter. QA Committee will recommend time frame for continued monitoring. ***5. By what date will the systemic changes be*** ***completed?*** August 15, 2013.	

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F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on interview and record review, the facility failed to attempt a gradual dose reduction for a psychotropic medication for 1 resident (Resident #56) of 10 residents reviewed for unnecessary medication. Findings include: Review of the clinical record for Resident #56 on 8/5/13 at 10:13 a.m., indicated the following: diagnoses included, but were not limited to, CHF	F000329	It is the policy of this provider to ensure that residents are not given unnecessary medications. Further, this provider participates voluntarily in the CMMS directed QIO antipsychotic reduction project nationwide. The provider asserts that this resident's care complied with the regulations in effect at the time this alleged non-compliance occurred. Present regulations went into effect May 24th, 2013. IDR (informal dispute resolution) is respectfully requested. We seek expungement as a remedy. 1.	08/13/2013

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	(congestive heart failure), COPD (chronic obstructive pulmonary disease), HTN (hypertension), diabetes mellitus, dementia, depression, and anxiety. A Nurse's Notes for Resident #56, dated 9/29/12, indicated she was anxious and refusing to wear O2 (oxygen) as ordered, stating "You are poisoning me with this." A Social Service Progress Note for Resident #56, dated 10/1/12, indicated nursing documented on 9/29/13, she was refusing to wear her O2 and stated she was being poisoned. The note also indicated the nurse attempted to redirect the resident with several interventions and none were successful. PRN (as needed) Ativan (anti-anxiety medication) 0.5mg. (milligram) was given. A Behavior Health Assessment/Evaluation for Resident #56, dated 10/3/12, indicated she was referred for an evaluation and assessment of her thought process and moods due to periods of anxiety and paranoia. The evaluation also indicated she had begun to refuse care. The impression from the evaluation indicated her presentation		What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice? Resident #56 remains on Seroquel 25 mg q hs (given at bedtime) and remains stable w/o symptoms of paranoia. The physician's order states that dose reduction is medically contraindicated. The attending physician was contacted for dose reduction order as a result of this finding. He reiterated his previous order. A request for pharmacist consult on this resident is placed and will occur next visit. 2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken? Other residents with the propensity to be affected by the same alleged deficient practice would be identified as those residents on psychotropic medications. Eight residents were so identified. The identified residents are included in a monthly Behavioral Committee meeting, which includes the Consulting Pharmacist. The Consulting Pharmacist reviews the medication regimen and periodically requests GDR within a timeframe not to exceed six months. Any recommendations for GDR are subject to approval by the attending physician, who determines within his scope of practice that such GDR is	

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	was of a combination of psychomotor restlessness and paranoia about her care and surroundings plus cognitive loss. The impression from the evaluation also indicated a low dose of a routine antipsychotic like Seroquel 12.5 mg (milligrams) BID (twice a day) might be considered to address the paranoia and the belief staff were poisoning her. A Social Service Progress Note for Resident #56, dated 10/10/12, indicated she was anxious and voiced people were laughing at her. A Nurse's Notes for Resident #56, dated 10/11/12 at 1:30 a.m., indicted she was disoriented and "afraid of the boogie man." The note also indicated Ativan 0.5mg. was given and was effective. The note further indicated a new order was received. A physician's order for Resident #56, dated 10/11/12 at 1:30 a.m., indicated Seroquel 50 mg every day HS (hour of sleep). The order also indicated to give one time dose Seroquel 50 mg orally today when available, then begin HS. A Nurse's Notes for Resident #56, dated 10/11/12 at 10:00 p.m., indicated she was given Seroquel at		medically appropriate. In addition, these residents receive periodic monitoring for side effects resulting from antipsychotic medication regimen. 3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? The DON(designee) will audit those residents on antipsychotic medication to assure that they have care planned a GDR if NOT medically contraindicated. 4. How will the corrective actions be monitored to ensure that the deficient practice does not recur? The DON(designee) will report the results of the audit to the QAPI Committee for review and recommendation monthly for two months and quarterly thereafter. QAPI Committee will recommend time frame for continued monitoring. 5. Date of completion: August 13, 2013.	

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	5:30 p.m. A Social Service Progress Note for Resident #56, dated 10/11/12, indicated she continued to display paranoia and continued to remove her oxygen. The note also indicated she was observed swearing at family and becoming easily agitated. A Behavior Summary for Resident #56, dated 10/17/12, indicated she had displayed episodes of delusional thinking and paranoia. The summary also indicated she was receiving Seroquel 50 mg HS. A facility fax to the physician of Resident #56, dated 10/31/12, indicated Seroquel 50 mg HS was prescribed on 10/11/12, The fax also indicated she had 2 falls within 1 week of taking the Seroquel and the medication was making her very tired into the morning. The fax further recommended the Seroquel be decreased to 25 mg HS. This recommendation was approved by the physician and the Seroquel was changed to 25 mg HS on 10/31/12. Review of the Nurse's Notes for Resident #56, dated 11/1/12 through 2/19/13, did not indicate any further episodes of paranoia or delusional			

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	thinking. Care Plan Elements/Comments for Resident #56, dated 12/6/12 and 12/27/12 indicated she only voiced feeling down and having trouble sleep under the mood/behavior section. A Request for Gradual Dose Reduction/Contraindication for Resident #56, dated 2/20/13, indicated she was receiving Ativan 0.5 mg PRN, Seroquel 25 mg HS, Ambien (hypnotic) 5 mg PRN, and Celexa (anti-depressant) 10 mg daily. The physician declined to reduce any of the medication due to: most recent attempt to reduce medication resulted in return and/or worsening of resident condition, and reduction was likely to impair the resident's function or increase distressed behavior. No specific recommendations were made for the Seroquel, although a reduction on 10/31/12 was successful. Review of the Nurse's Notes for Resident #56, dated 2/20/13 through 8/6/13, did not indicate any further episodes of paranoia or delusional thinking. Care Plan Elements/Comments for Resident #56, dated 3/14/13, 6/6/13, and 7/11/13, indicated she only			

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	voiced feeling down and having trouble sleeping under mood/behavior section. Review of the clinical record for Resident #56 indicated there was no further attempt by the facility for a GDR (gradual dose reduction) of the Seroquel since the reduction on 10/31/12. Physician orders for Resident #56, dated for the month of July, 2013, indicated she received: Ativan 0.25 mg daily, Ativan 0.25 mg TID (three times a day) PRN, Celexa 10 mg daily, and Seroquel 25 mg HS for dementia, started 11/1/12. A facility care plan for Resident #56, with a start date of December, 2012, indicated the problem area of potential for side effects related to the use of antipsychotic agents. Approaches to the problem included, but were not limited to, observe resident for potential side effects, notify physician if side effects are observed, non-pharmacological interventions for anti-psychotics, and gradual dose reduction will be attempted as scheduled. Social Service staff #2 was interviewed on 8/6/13 at 11:12 a.m.			

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	During the interview she indicated residents who receive psychotropic medications were reviewed monthly. Social Service staff #2 was interviewed on 8/6/13 at 1:40 p.m. During the interview she indicated she was not able to determine why Resident #56's physician had started the Seroquel at 50 mg daily, instead of the 12.5 mg daily recommended in the Behavior Health Assessment/Evaluation. Social Service staff #2 was interviewed on 8/7/13 at 1:50 p.m. During the interview she indicated nursing staff were to document behaviors in nursing notes and Certified Nursing Assistants were to document in the care tracker system. She also indicated she could only find documentation of anxiety in Resident #56 since November, 2012. She further indicated there had not been any incidents of paranoia documented for Resident #56 since the Seroquel was decreased on 10/31/12. A current facility policy "Anti-Psychotic Drugs", revised on October, 2011 and provided by the DON on 8/7/13 at 10:39 a.m., indicated "...The physician in coordination with the			

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	Behavior Management team will continually re-evaluate the need for the drug and suggest "drug holidays" or reduction of dosage to the lowest possible dose to control symptoms...." 3.1-48(a)(2)			

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F000428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.			
	Based on interview and record review the facility failed to act on the recommendations of the Consultant Pharmacist for 4 of 10 residents reviewed for unnecessary medications. (Resident # 5, # 33, #37, # 56) Findings include: 1. On 8/5/13 at 10:10 a.m. review of the clinical record for resident #37 indicated he was admitted to the facility on 4/27/12, his diagnoses including but not limited to Parkinson's Disease, depression, peripheral edema, urinary incontinence, sleep apnea, fatigue, weakness, cellulitis, dermatitis, dementia, mononeuritis, neuropathy, encephalopathy, CKD (chronic kidney disease), history of falls, orthostatic hypotension, herniated disc, history of prostate cancer, history of head trauma, acute confusional state, brain	F000428	It is the policy of this provider to review and revise any irregularities based on the pharmacist's recommendation report. ***1. What corrective action(s) will be accomplished*** ***for those residents found to have been affected*** ***by the deficient practice?*** Residents #37 & 56 were started on monthly orthostatic blood pressure checks. Resident #33 Vitamin D and Calcium were changed per pharmacy recommendation. Resident #5 is	08/13/2013

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	disease. Review of Consultant Pharmacist's Medication Regimen Review for Resident #37, dated 2/14/13, indicated, "...Resident #37 receives Seroquel (antipsychotic medication). Federal guidelines require that we monitor for orthostatic hypotension (postural drop in blood pressure) since this is a common occurrence of antipsychotics....I would recommend that nursing start to check a monthly laying, then sitting, then standing BP (blood pressure) consecutively as a nursing measure. If he is not able to stand then just a laying then sitting BP would be sufficient...." Review of Resident #37's clinical records of vital signs indicated only one BP was recorded.		scheduled for BMP and CBC every 3 months. ***2. How other residents having the potential to be*** ***affected by the same deficient practice will be*** ***identified and what corrective action(s) will be*** ***taken?*** Other residents having the potential to be affected by the same deficient practice would be identified as those with lab recommendations from the consultant pharmacist. From April 2013 to present, all pharmacy recommendation were audited to assure that all pharmacy recommendation have been addressed. ***3. What measures will be put***	

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			into place or what ***systemic changes will be made to ensure that the*** ***deficient practice does not recur?*** A system has been developed to assure the recommendations are reviewed monthly. Pharmacist's report will be sent to DON/Designee. DON/Designee will distribute the recommendations to the appropriate physician. DON/Designee will monitor/audit monthly for return response and accuracy of order. ***4. How the corrective action(s) will be monitored*** ***to ensure the deficient practice will not recur?*** Result of the audit will be submitted to the	

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	2. On 8/5/13 at 2:45 p.m. review of the clinical record for resident #33 indicated she was admitted to the facility on 8/6/08 with diagnoses including but not limited to congestive heart failure, atrial fibrillation, and osteoporosis. Review of a "Note to Attending Physician/Prescriber" which came from the pharmacy, dated 3/20/13, indicated the following: "Resident #33 was started on Vitamin D 50,000 BID (two times daily) x 12 weeks and also Vitamin D 5,000 IU QD (every day) due to a level of 14		QA Committee for review and recommendation monthly for two months and quarterly thereafter. QA Committee will recommend time frame for continued monitoring. ***5. What date will the systemic changes be*** ***completed?*** August 13, 2013.	

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	mg/dL. However the Vitamin D 5,000 IU is not covered and the facility is having to pay out of pocket for this Would you consider changing her to this alternative: 1. Stop Vitamin D 5,000 IU QD and just change her to Vitamin D 50,000 IU Q (every) week. 2. Change Calcium 500 mg BID to Calcium+D 600/400 IU BID. Review of a "Note to attending Physician/Prescriber" which came from the pharmacy with a date of 5/10/13 indicated the following: "Resident #33 is on Vitamin D 5000 IU QD and Calcium 500 mg BID. She is on 20 routine medications. Could we change her to Vitamin D 50,000 IU q month and Calcium+D 600/400 mg BID when her supply is exhausted to provide daily Vitamin D supplementation and also to try and decrease medication burden a bit? On 8/5/13 at 3:00 p.m. review of resident #33's physician orders indicated she was still receiving Vitamin D 5000 every day, and Calcium 500 milligrams twice daily. 3. A review of Resident #5's clinical			

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	record began on 8-5-2013 at 10:23 a.m., indicated diagnoses included but were not limited to, cerebral vascular attack, speech disturbance, anemia, atrial fibrillation, hypertension, depression, thrombocytopenia, anxiety, dyspnea, tremors and dehydration. A consultant pharmacist recommendation dated 2-14-2013, indicated Resident #5 had labs ordered every 3 months for a basic metabolic panel (BMP) and complete blood count (CBC). The consultant pharmacist indicated last laboratory draws were done in August 2012 and since the resident was off hospice to be sure the labs were completed. The April 2013 recapitulation indicated laboratory orders for a BMP and a CBC to be completed every 3 months. A review of laboratory results in Resident #5's clinical record indicated a CBC and BMP were completed on 2-26-2013 and a BMP was completed on 5-14-2013. There were no laboratory results for a CBC as recommended/ordered for May 2013. 4. Review of the clinical record for Resident #56 on 8/5/13 at 10:13 a.m., indicated the following: diagnoses			

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	included, but were not limited to, CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease), HTN (hypertension), diabetes mellitus, dementia, anxiety, and depression. A Behavior Health Assessment/Evaluation for Resident #56, dated 10/3/12, indicated to consider a routine antipsychotic like Seroquel to address the paranoia. A physician's order for Resident #56, dated 10/11/12, indicated Seroquel 50 mg (milligrams) every day at HS (hour of sleep). A Consultant Pharmacist's Medication Regimen Review for Resident #56, dated 3/19/13, indicated she received Seroquel and the medication could commonly cause orthostatic hypotension as a result. The review also recommended a monthly nursing check at laying, then sitting, then standing blood pressure consecutively and to document on the MAR (Medication Administration Record) as a nursing measure. A review of the MAR's for Resident #56 for the months of March, 2013, April, 2013, May, 2013, June, 2013, July, 2013, and August, 2013,did not			

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	indicate orthostatic blood pressures were taken. During an interview with DON (Director of Nursing) on 8/5/13 at 3:10 p.m., indicated the Pharmacist's Recommendation to monitor resident for orthostatic hypotension was not followed by nursing to monitor Resident #37 orthostatic blood pressure by taking his blood pressures laying, sitting and standing. LPN #1 was interviewed on 8/7/13 at 10:42 a.m. During the interview she indicated only weekly blood pressures were taken on Resident #56. She also indicated orthostatic blood pressures were not taken. On 8/7/13 at 10:40 a.m. interview with the Director of Nursing indicated she did not know what the system was for getting the pharmacy recommendations to the physicians and returned to the facility. On 8/7/13 at 10:50 a.m. interview with licensed nurse # 1 indicated the pharmacy faxes "Note to Attending Physician/Prescriber" forms to the facility and the nurses then fax the form to the physicians. Nurse #1 indicated she keeps a folder with the			

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	faxed forms, and when she gets the returned fax from the physician she places it in the clinical record. During an interview with the Director of Nursing (DON) on 8-6-2013 at 9:31 a.m., the DON indicated the lab orders for the CBC from the physician recapitulation for April 2013 were not entered in the laboratory book and the CBC was not done. During an interview with the Medical Records Staff #6 on 8-7-2013 at 8:40 a.m., the Medical Records Staff #6 indicated she did not receive a copy of the Consultant Pharmacist's Medication Regimen Review dated 2-14-2013 which recommended labs for a CBC and BMP every 3 months. She indicated she did not know to place the CBC and BMP on the lab calendar. On 8/7/13 at 8:30 a.m., the DON provided the facility policy titled, Drug Regimen Review, with date revised: 04/10, indicated, "...The Consultant Pharmacist reviews the medication regimen of each resident at least monthly. Findings and recommendations are reported to the Administrator, Director of Nursing, the responsible Physician and the			

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	Medical Director, when appropriate....The Consultant Pharmacist documents all potential or actual significant pharmaceutical documentation problems found relating to medications and communicates them to the DON through Pharmacist Record Review....the response is documented on the Consultant Pharmacist review record or in the resident's medical record....the Consultant Pharmacist utilizes federally-mandated standards of care, in addition to other applicable standards...." 3.1-25(i)			

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F000514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to follow their policy and procedure for ensuring physician progress notes were available in the clinical record for 9 of 36 residents' records reviewed. (Residents #25, #26, #37, #43, #44, # 51, #52, # 60, #64) Findings include: 1. A review of the clinical record for Resident #37 on 8/5/13 at 10:10 a.m., indicated the following diagnoses included but were not limited to, Parkinson's Disease, depression, peripheral edema, urinary incontinence, sleep apnea, fatigue, weakness, cellulitis, dermatitis, dementia, mononeuritis, neuropathy, encephalopathy, CKD (chronic kidney	F000514	It is the policy of this provider to ensure that the documentation in clinical records is accurate and complete. ***1. What corrective action(s) will be accomplished*** ***for the resident(s) found to be affected by the*** ***alleged deficient practice?*** All Residents whose charts were lacking physician progress notes have had the	08/16/2013

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	disease), history of falls, orthostatic hypotension, herniated disc, history of prostate cancer, history of head trauma, acute confusional state, brain disease. A review of the Doctor's Progress Notes for Resident #37 indicated he was seen by the Nurse Practitioner on 7/17/13. The clinical record for Resident #37 did not contain the Nurse Practitioner's progress notes from the visit on 7/17/13. 2. Review of the clinical record for Resident # 60 on 8/5/13 at 2:50 p.m., indicated the following diagnoses included but not limited to, COPD (chronic obstructive pulmonary disease), dementia of Alzheimer's type with sad mood, hypothyroidism, HTN (hypertension), hyperlipidemia, fracture of C2 vertebra, generalized pain, GERD (gastroesophageal reflux disease), insomnia, nausea, anemia, migraine headaches. A Doctor's Progress Notes for Resident #60 indicated she was seen by the Physician on 7/3/13. The Physician Progress Notes for the		progress notes signed by the physician and placed on the respective chart. ***2. How will the facility identify other residents having*** ***the potential to be affected by the same alleged*** ***deficient practice and what corrective action will be*** ***taken?*** Residents with the propensity to be affected by the same alleged deficient practice would be identified as those whose attending physician was a specific physician. Said charts were audited and residents whose charts were lacking physician progress notes have had the progress notes signed by the physician and placed on the respective chart.	

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	Physician visit on 7/3/13 was not present on Resident #60's clinical record. 3. A review of the clinical record for Resident #26 on 8/6/2013 at 11:30 a.m., indicated the following diagnoses included but were not limited to, Alzheimer's Disease, depression, DM II (diabetes mellitus type II), CVA (cerebral vascular accident or a stroke), CAD (coronary artery disease), HTN (hypertension), COPD (chronic obstructive pulmonary disease), gout, hypokalemia, hyperlipidemia, history of right hip fracture with repair, history of MI (myocardial infarct or heart attack). A review of the Doctor's Progress Notes for Resident #26 indicated he was seen by the Physician on 7/3/13. The Physician Progress Notes for the Physician visit on 7/3/13 was not present on Resident #26's clinical record. 4. A review of the clinical record for Resident #43 on 8/6/2013 at 1:45 p.m., indicated the following diagnoses included but were not		***3. What measures will be put into place or what*** ***systemic changes will be made to ensure that the*** ***alleged deficient practice does not recur?*** The Medical Records designee will audit for physician's progress notes 72 hours (410AC16.2- 3.1-22(c)(2)) after each physicians' visit. The results of the audits will be communicated to Director of Nursing. The Director of Nursing or designee will immediately ensure the issue is addressed and corrected and that the resident's care remains medically appropriate. ***4. How will the corrective actions be monitored to*** ***ensure that the deficient***	

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	limited to, CAD (coronary artery disease), DM II (diabetes mellitus type II), HTN (hypertension), peripheral neuropathy, dementia, fatigue, headache, hyperlipidemia, hypothyroidism,actinic karatosis, impacted cerumen, otitis media, ear pain. A review of the Doctor's Progress Notes for Resident #43 indicated she was seen by the Nurse Practitioner on 7/17/13. The Nurse Practitiioner's Progress Notes for the visit on 7/17/13 was not present on Resident #43's clinical record. 5. A review of the clinical record for Resident #52 on 8/7/2013 at 8:40 a.m., indicated the following diagnoses included but were not limited to, dementia, HTN (hypertension), depression, anxiety, anemia, weakness, constipation, history of falls, history of UTI (urinary tract infection), history of right hip fracture with repair. A review of the Doctor's Progress Notes for Resident #52 indicated he was seen by the Physician on 7/3/13.		***practice does not recur?*** The DON will bring the results of the audits to the monthly QA&A/PI Committee meeting for review and recommendations. The QA&A/PI Committee will communicate to the Adams Health Network's Chief of Medical Staff and the Board of Directors, any patterned non-compliance and they shall determine sanctions. At that time, they will determine the continued frequency of audit. ***5. Date of Compliance:*** 08.16.2013	

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	The Physician Progress Notes for the Physician visit on 7/3/13 was not present on Resident #52's clinical record. 6. On 8/5/13 at 2:00 p.m. review of the clinical record for resident #51 indicated she was admitted to the facility on 6/18/11 with diagnosis including but not limited to cataracts, congestive heart failure, osteoporosis and cancer of the colon. Review of the clinical record indicated the Nurse Practitioner had visited the resident on 7/19/13 and documented that the physician notes were dictated, but there were no notes in the record for the 7/19/13 visit. 7. Review of the clinical record for Resident #64 on 8/6/13 at 8:46 a.m., indicated the following: diagnoses included, but were not limited to, dementia, depression, HTN (hypertension), hypothyroid, abnormal gait, constipation, wheezing, prostate CA, and urinary retention. A Doctor's Progress Notes for Resident #64 indicated he was seen by the Physician/Nurse Practitioner on 6/12/12 and 7/17/12. Review of the clinical record for Resident #64 indicated there was no			

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	report from the Physician/Nurse Practitioner for 7/7/13 in the clinical record. 8. A review of the clinical record for Resident #25 on 8-6-2013 at 9:41 a.m., indicated diagnoses included but were not limited to, acute renal failure, chronic kidney disease stage IV, acute kidney disease, atrial fibrillation, congestive heart failure, diabetes, hyperkalemia, hypothyroidism, cholecystits, metabolic encephalopathy, SIRS (Systemic Inflammatory Response Syndrome). A review of the Physician Progress Notes page in the Resident #25's record indicated a signature only from the nurse practitioner visit on 7-19-2013. The nurse practitioner progress notes were not in record from the 7-19-2013 visit. The most recent progress note in the clinical record for Resident #25 was for the nurse practitioner visit from 6-7-2013. 9. A review of the clinical record for Resident #44 on 8-5-2013 at 2:39 p.m., indicated diagnoses included but were not limited to dementia,			

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	history of falls, cataracts, hypertension, chronic obstructive pulmonary disease, anemia, confusion, atrial fibrillation and transient ischemic attack. A review of the Physician Progress Notes page in the Resident #44's record indicated a signature only from the nurse practitioner visit on 7-19-2013. The nurse practitioner progress notes were not in record from the 7-19-2013 visit. The most recent progress note in the clinical record for Resident #44's record was for the nurse practitioner visit from 5-7-2013. An interview with the Medical Records staff #6 on 8-7-2013 at 8:38 a.m., indicated the physician's office was notified on 8-6-2013 about the missing progress notes for the residents visited from July 2013. The Medical Records staff #6 indicated the progress notes from the nurse practitioner's visits were usually received 3 to 4 weeks after the nurse practitioner visit. During an interview with Medical			

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	Record #6 on 8/7/13 at 2:35 p.m., indicated the physician progress notes from 7/3/13 were brought to the facility today and also indicated the Physician/Nurse Practitioner progress notes for 7/17/13 are not yet available. During a review of the current policy "Physicians Services" dated 7/11 and provided by the Director of Nursing on 8-7-2013 at 8:30 a.m., the policy indicated "...at the option of the physician, required visits...may alternate between personal visits by the physician and visits by a...nurse practitioner.... A progress note will be written and signed/dated by the physician at the time of each visit...dictated notes must be filed in the clinical record within 72 hours or 3 business days of the visit...." 3.1-50(f)(5)			

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